

**LOUISIANA STATE BOARD OF MEDICAL EXAMINERS
(LSBME)**

Main Phone: (504) 568-6820 (auto attendant)



CLINICAL LABORATORY PERSONNEL

APPLICATION AND INSTRUCTIONS

(Rev. 080305)

Visit the LSBME website at www.lsbme.louisiana.gov

Application Processing Addresses:

LSBME, P.O. Box 54383, New Orleans, LA 70154-4383

Criminal Background Check Address:

LSBME, ATTN.: CB, P. O. Box 30250, New Orleans, LA 70190-0250

Physical Address:

630 Camp Street, New Orleans, LA 70130

General Correspondence Mailing Address: P.O. Box 2270, New Orleans, LA 70176-2270

Louisiana State Board of Medical Examiners

P. O. Box 54383, New Orleans, LA 70154-4383
Telephone: (504) 568-6820

Clinical Laboratory Personnel

APPLICATION CHECKLIST

*Please enclose all items listed below to avoid delays in the application process.

1. ☐ Certified copy of birth certificate. BIRTH CARDS ARE NOT ACCEPTED.
 2. ☐ Notarized copy of marriage certificate (if applicable).
 3. ☐ Copy of Certificate of Naturalization (if not U.S. Citizen).
 4. ☐ Copy of Certificate of Citizenship (if applicable).
 5. ☐ ALL time accounted for from High School date.
 6. ☐ Official copy of High School/GED transcript mailed directly to LSBME Office (Lab Assistants and Phlebotomists only).
 7. ☐ Official transcript of B.S. degree for:
 - a. Clinical Laboratory Scientist-Generalist
 - b. Clinical Laboratory Scientist-Specialist
 - c. Cytotechnologist
 8. ☐ Official transcript of Associate degree for:
 - a. Clinical Laboratory Scientist-Technician
 9. ☐ Licensure Fees
 - a. **\$25.00** for Laboratory Assistant and Phlebotomist
 - b. **\$50.00** for CLS-G, CLS-S, CLS-T, and Cytotechnologists
- Make Check Or Money Order Payable To: CLINICAL LABORATORY PERSONNEL COMMITTEE**
10. ☐ Notarize all required pages. If you answer "YES" on the Oath or Affirmation page, you must send a notarized sworn statement explaining your answer.
 11. ☐ Send request form to Certification Agency asking that they send documentation of examination scores to the LSBME.
 12. ☐ Copy of ALL appropriate certificates. Also copy of licenses from other states.
 13. ☐ Order the Criminal Background Check materials by email at lsbmemat@lsbme.louisiana.gov or write to:
LSBME-CB Department P.O. Box 30250, New Orleans, LA 70190-0250. (Fee is \$50.00)
Send money order [made payable to Department of Safety and Corrections] with completed fingerprint cards to LSBME,
ATTN: CB Dept. P.O. Box 54403, New Orleans, LA 70154-4403.
 14. ☐ A recent **2x2 passport quality photograph** attached to the Certificate of Program Director form. This form must be notarized.
 15. ☐ Reinstatement of license: You must present 12 CEU's (within last 6 months). Reinstatement fee due: **\$100.00**. (\$50.00 penalty fee plus \$50.00 renewal fee)

***Once your application has been submitted to this Board office, please **allow 30 days BEFORE calling** to request the status of your application.

PART II: INSTRUCTIONS FOR CLINICAL LABORATORY PERSONNEL

GENERAL INSTRUCTIONS

See "Examination Contacts for Clinical Laboratory Personnel" to request that an examination scores report is forwarded by the examiner directly to the LSBME, Office of Licensure, P.O. Box 2270, New Orleans, LA 70176-2270.

CLINICAL LABORATORY SCIENTIST - GENERALIST

To be eligible for licensure as a clinical laboratory scientist-generalist, an applicant, in addition to satisfaction of the procedural requirements for licensure, shall have successfully completed an approved nationally recognized certification examination for such clinical laboratory personnel classification, as developed and administered by one of the following organizations:

1. American Society of Clinical Pathologists (ASCP);
2. National Certification Agency (NCA);
3. American Medical Technologists (AMT); or
4. American Association of Bioanalysts (AAB). provided, however, that an applicant for licensure as a CLS-G who has, prior to January 1, 1995, successfully completed the certification examination for such clinical laboratory personnel classification developed and administered by the United States Department of Health, Education, and Welfare (HEW) (predecessor to the Department of Health and Human Services) shall also be eligible for licensure as a clinical laboratory scientist-generalist.

Checklist

- Official transcript from accredited college or university with a major in one of the chemical, physical, or biological sciences.
- Passing scores on a nationally recognized certification exam.
- 1 recent photograph.
- Criminal Background Check Materials.
- See discussion of birth certificates and passports herein.

CLINICAL LABORATORY SCIENTIST - SPECIALIST

To be eligible for licensure as a clinical laboratory scientist-specialist, an applicant, in addition to satisfaction of the procedural requirements for licensure, shall:

1. possess a baccalaureate or more advanced degree from an accredited college or university with a major in one of the chemical, physical, or biological sciences; and
2. have successfully completed an approved nationally recognized certification examination for such clinical laboratory personnel classification, as developed and administered by one of the following organizations:
 - a. American Society of Clinical Pathologists (ASCP);
 - b. National Certification Agency (NCA);
 - c. American Society of Microbiology (ASM);
 - d. American Association of Clinical Chemistry (AACC);
 - e. American Board of Immunology (ABI);
 - f. American Board of Bioanalysts (ABB); or
 - g. American Board of Forensic Toxicology (ABFT).

Checklist

- Official transcript for Baccalaureate or more advanced degree from an accredited college or university with a major in one of the chemical, physical, or biological sciences.
- Passing scores on a certification examination from one of the above accredited organizations.
- 1 recent photograph.
- Criminal Background Check Materials.
- See discussion of birth certificates and passports herein.

CLINICAL LABORATORY SCIENTIST - TECHNICIAN

To be eligible for licensure as a clinical laboratory scientist-technician, an applicant, in addition to satisfaction of the procedural requirements for licensure, shall have successfully completed an approved nationally recognized certification examination for such clinical laboratory personnel classification, as developed and administered by one of the following organizations:

1. American Society of Clinical Pathologists (ASCP);
2. National Certification Agency (NCA);
3. American Medical Technologists (AMT); or
4. American Association of Bioanalysts (AAB)

Checklist

- Official transcript from accredited college or university
- Passing scores on a nationally recognized certification exam.
- 1 recent photograph.
- Criminal Background Check Materials.
- See discussion of birth certificates and passports herein.

CYTOTECHNOLOGIST

To be eligible for licensure as a cytotechnologist, an applicant, in addition to satisfaction of the procedural requirements for licensure, shall:

1. possess a baccalaureate degree from an accredited college or university, fulfill the educational requirements necessary to enroll in a school of cytotechnology, complete one full year of full-time cytotechnology experience or its equivalent in an approved school of cytotechnology, and successfully complete an approved nationally recognized certification examination for such clinical laboratory personnel classification, as developed and administered by one of the following organizations:
 - a. American Society of Clinical Pathologists (ASCP); or
 - b. International Academy of Cytology (IAC);

Checklist

- Official transcript from an accredited college or university.
- Proof of one-year full time cytotechnology experience or equivalent.
- Passing scores on a nationally recognized certification examination.
- 1 recent photograph.
- Criminal Background Check Materials
- See discussion of birth certificates and passports herein.

LABORATORY ASSISTANT

To be eligible for licensure as a laboratory assistant, an applicant, in addition to satisfaction of the procedural requirements for licensure, shall:

1. possess a high school diploma or its equivalent;
2. document to the board, in a form sufficient to and upon the recommendation of the committee, training as evidence of competency in the basic practice of clinical laboratory science. For this purpose, successful completion of the certification examinations for laboratory assistants offered by the American Association of Bioanalysts and the American Society of Clinical Pathologists shall be deemed a conclusive, but not the exclusive, means of documenting competency in the basic practice of clinical laboratory science;
3. prior to the performance of requisite moderate complexity testing, have provided to the applicant's employer or laboratory director documentation of training appropriate for the testing performed. Such documentation shall ensure that the applicant has all of the following:
 - a. the skills required for proper specimen collection, including patient preparation, if applicable, labeling, handling, preservation or fixation, processing or preparation, transportation, and storage of specimens;
 - b. the skills required for implementing all standard laboratory procedures;
 - c. the skills required for performing each test method and for proper instrument use;
 - d. the skills required for performing preventive maintenance, troubleshooting, and calibration procedures related to each test performed;
 - e. a working knowledge of reagent stability and storage;
 - f. the skills required to implement the quality control policies and procedures of the laboratory;
 - g. an awareness of the factors that influence test results; and

- h. the skills required to assess and verify the validity of patient test results through the evaluation of quality control sample values prior to reporting patient test results; and
4. have provided to the committee or board, upon good cause shown, the documentation of training appropriate for the requisite moderate complexity testing to be performed.

Checklist

- Transcript indicating graduation from high school
- 1 recent photograph
- Criminal Background Check Materials
- Documentation of training,
- See discussion of birth certificates and passports herein.

PHLEBOTOMIST

To be eligible for certification as a phlebotomist, an applicant, in addition to satisfaction of the procedural requirements for certification, shall:

1. have successfully completed a certification examination approved or written and administered by the board and the committee following completion of a training program for phlebotomists satisfactory to the board, upon recommendation of the committee, consisting of a minimum of 20 lecture hours or adequate practical hours to ensure that the applicant possesses:
 - a. the skills required for proper specimen collection, including patient identification and preparation, labeling, handling, preservation, processing, transportation, and storage of specimens;
 - b. the skills required for selecting the appropriate type of tube to collect for each test;
 - c. the skills required for performing preventive maintenance, troubleshooting, and calibration procedures related to each test performed;
 - d. a working knowledge of reagent stability and storage;
 - e. the skills required to perform quality control procedures;
 - f. an awareness of the factors that influence test results;
 - g. a working knowledge of the actions of various anticoagulants;
 - h. a working knowledge of the anatomy and physiology of blood vessels and the circulatory system and blood;
 - i. a working knowledge of the components and functions of those components of blood to include, RBC, WBC, platelets, and plasma or serum;
 - j. a working knowledge of primary hemostasis;
 - k. a working knowledge of laboratory safety to include OSHA standards for handling bloodborne pathogens;
 - l. a working knowledge of the various isolation procedures and infection control;
 - m. a working knowledge of various medical terms and laboratory tests;
 - n. a working knowledge of the requirements of special laboratory tests;
 - o. a working knowledge of the clinical laboratory;
 - p. a working knowledge of the major tests performed in the clinical laboratory and specimen requirements;
 - q. a working knowledge of aseptic techniques and methods of sterilization; and
 - r. completion of 100 successful venipunctures and 25 successful capillary collections; or
2. have successfully completed an approved nationally recognized certification examination for such clinical laboratory personnel classification, as developed and administered by one of the following organizations:
 - a. American Society of Clinical Pathologists (ASCP);
 - b. National Certification Agency (NCA);
 - c. American Society of Phlebotomy Technicians (ASPT);
 - d. National Phlebotomy Association (NPA);
 - e. American Medical Technologists (AMT);
 - f. American Association of Blood Banks;
 - g. National Allied Health Test Registry (NAHTR); or
 - h. International Academy of Phlebotomy Science (IAPS)
 - i. National Healthcareer Association (NHA)

Checklist

- 1 recent photograph.
- Criminal Background Check Materials
- Passing scores on a nationally recognized certification examination.
- See discussion of birth certificates and passports herein.

Examinations Contacts for Clinical Laboratory Personnel
(Rev. 08182006)

**Clinical Laboratory Scientist-Generalist &
Clinical Laboratory Scientist-Technician**

American Medical Technologist

10700 West Higgins Road
Rosemont, IL 60018
Phone: 800-275-1268
or 847-823-5169
Fax: 847-823-0458
Email: AMTMAIL@aol.com
Website: www.amt1.com

American Society for Clinical Pathology

33 West Monroe St, Suite 1600
Chicago, IL 60603-5300
Phone: 800-267-2727
Fax: 314-541-4845
Email: info@ascp.org
Website: www.ascp.org

American Association of Bioanalysts (AAB)

906 Olive Street, Suite 1200
Saint Louis, MO 63101-1434
Phone: 314-241-1445
Fax: 314-241-1449
Email: aab@aab.org
Website: www.aab.org

National Credentialing Agency

PO Box 15945-289
Lenexa, KS 66285
Phone: 913-438-5110 ext. 4647
Fax: 913-599-5340
Email: nca-info@goamp.com
Website: www.nca-info.org

Clinical Laboratory Scientist-Specialist

American Association for Clinical Chemistry

1850 K St, NW, Suite 625
Washington, DC 20006
Phone: 202-857-0717 or
1-800-892-1400
Fax: 202-887-5093
Email: info@aacc.org
Website: www.aacc.org

American Board of Allergy and Immunology

510 Walnut Street, Suite 1701
Philadelphia, PA 19106
Phone: 215-592-9466
Fax: 215-592-9411
Email: abai@abai.org
Website: www.abai.org

American Board of Bioanalysis (ABB)

906 Olive Street, Suite 1200
Saint Louis, MO 63101
Phone: 314-241-1445
Fax: 314-241-1449
Email: abb@abb.org
Website: www.abb.org

American Board of Forensic Toxicology

410 North 21st Street
Colorado Springs, CO 80904
Phone: 719-636-1100
Fax: 719-636-1993
Email: kwrasse@aafs.org
Website: www.abft.org

American Board of Histocompatibility and
Immunogenetics

P. O. Box 19173
Lenexa, KS 66285-9173
Phone: 913-541-0009
Fax: 913-599-5340
Email: bcrowley@goAMP.com
Website: www.ashi-hla.org/abhi

American Board of Medical Genetics

Administrative Office
9650 Rockville Pike
Bethesda, MD 20844-3998
Phone: 301-634-7316
Fax: 301-634-7320
Email: abmg@genetics.faesb.org
Website: www.abmg.org

American Society for Microbiology

1752 N Street NW
Washington, DC 20036
Phone: 202-737-3600 or
1-800-546-2416
Fax: 202-942-9369
Webmaster@asm.usa.org
Website: www.asm.org

American Society for Clinical Pathology

33 West Monroe St, Suite 1600
Chicago, IL 60603-5300
Phone: 800-267-2727
Fax: 314-541-4845
Email: info@ascp.org
Website: www.ascp.org

Clinical Ligand Assay Society

3139 S Wayne Road
Wayne, MI 48184
Phone: 734-722-6290
Fax: 734-722-7006
Email: clas@clas.org
Website: www.clas.org

American Association of Bioanalysts (AAB)

906 Olive Street, Suite 1200
Saint Louis, MO 63101-1434
Phone: 314-241-1445
Fax: 314-241-1449
Email: aab@aab.org
Website: www.aab.org

Cytotechnologist

American Society for Clinical Pathology

33 W Monroe St, Ste 1600
Chicago, IL 60603-5300
Phone: 800-267-2727
Fax: 314-541-4845
Email: info@ascp.org
Website: www.ascp.org

Laboratory Assistant

American Medical Technologists

10700 West Higgins Road
Rosemont, IL 60018
Phone: 800-275-1268
or 847-823-5169
Fax: 847-823-0458
Email: AMTMAIL@aol.com
Website: www.amt1.com

American Association of Bioanalysts (AAB)

906 Olive Street, Suite 1200
Saint Louis, MO 63101-1434
Phone: 314-241-1445
Fax: 314-241-1449
Email: aab@aab.org
Website: www.aab.org

Phlebotomist

American Association of Blood Banks

8101 Glenbrook Road
Bethesda, MD 20814
Phone: 301-907-6977
Fax: 301-907-6895
Email: educ@aab.org

American Medical Technologist

10700 West Higgins Road
Rosemont, IL 60018
Phone: 800-275-1268 or 847-823-5169
Fax: 847-823-0458
Email: AMTMAIL@aol.com
Website: www.amt1.com

American Society for Clinical Pathology

33 West Monroe St, Suite 1600
Chicago, IL 60603-5300
Phone: 800-267-2727
Fax: 314-541-4845
Email: info@ascp.org
Website: www.ascp.org

American Society of Phlebotomy Technicians

P. O. Box 1831
Hickory, NC 28603
Phone: 828-294-0078 Msg line
Fax: 828-327-2969
Email: office@aspt.org

Int'l Academy of Phlebotomy Sciences

629 D' Lyn Street
Columbus, OH 43228
Phone: 614-878-7751

National Assoc for Health Professionals

P. O. Box 459
Gardner, KS 66030
Phone: 800-444-0839 NAHP/NAHTR
Fax: 913-856-6125
Website: www.nahpusa.com

National Center for Competency Testing

7007 College Blvd Ste 250
Overland Park, KS 66211
Phone: 913-498-1000
or 800-875-4404
Fax: 913-498-1243
Email: www.ncctinc.com

National Healthcareer Association

134 Evergreen Pl, 9th Floor
East Orange, NJ 07018
Phone: 800-499-9092
Fax: 973-678-7305
Email: Info@NHANOW.com

National Phlebotomy Association

1901 Bright Seat Road
Landover, MD 20785
Phone: 301-386-4200
Fax: 301-386-4203
Email: naltphle@aol.com
www.nationalphlebotomy.org

LOUISIANA STATE BOARD OF MEDICAL EXAMINERS

FEE SCHEDULE FOR CLINICAL LABORATORY PERSONNEL

(Rev 040303)

Initial Licensure Fees

Note: If applying for a temporary permit, permanent licensure fee must accompany the temporary permit fee.

Profession		Form Of Payment	Payable To	Amount	Send To	Total
ALL APPLICANTS: FINGERPRINTS		Money Order	La. Department of Public Safety and Corrections	\$50.00	LSBME	\$50.00
For LSBME to return documents to applicant in U.S. by U.S. Certified Mail, Return Receipt Requested.		Check or Money Order	LSBME	\$2.55	LSBME	\$
For LSBME to return documents to applicant in U.S. by courier.		SEE INSTRUCTIONS				-----
ALLIED HEALTH CLINICAL LABORATORY PERSONNEL	Generalist	Check or Money Order	CLPC	\$50.00	LSBME	\$
	Generalist Trainee	Check or Money Order	CLPC	\$50.00	LSBME	\$
	Generalist Temporary Permit	Check or Money Order	CLPC	\$50.00	LSBME	\$
	Specialist	Check or Money Order	CLPC	\$50.00	LSBME	\$
	Specialist Trainee	Check or Money Order	CLPC	\$50.00	LSBME	\$
	Specialist Temporary Permit	Check or Money Order	CLPC	\$50.00	LSBME	\$
	Technician	Check or Money Order	CLPC	\$50.00	LSBME	\$
	Technician Trainee	Check or Money Order	CLPC	\$50.00	LSBME	\$
	Technician Temporary Permit	Check or Money Order	CLPC	\$50.00	LSBME	\$
	Cytotechnologist	Check or Money Order	CLPC	\$50.00	LSBME	\$
	Cytotechnologist Trainee	Check or Money Order	CLPC	\$50.00	LSBME	\$
	Cytotechnologist Temporary Permit	Check or Money Order	CLPC	\$50.00	LSBME	\$
	Laboratory Assistant	Check or Money Order	CLPC	\$25.00	LSBME	\$
	Laboratory Assistant Trainee	Check or Money Order	CLPC	\$25.00	LSBME	\$
	Phlebotomist	Check or Money Order	CLPC	\$25.00	LSBME	\$
	Phlebotomist Temporary Permit	Check or Money Order	CLPC	\$25.00	LSBME	\$
TOTAL						\$

*Must Complete Waiver Form

NOTE: The LSBME will notify applicant if insufficient monies are remitted.

Renewal Fees¹

All Clinical Laboratory Personnel Licenses Renewal Due December 31.		
Discipline	Scheduled Renewal Fee	After Due Date
Generalists/Trainees	\$50.00	\$100.00
Technicians/Trainees	\$50.00	\$100.00
Specialists/Trainees	\$50.00	\$100.00
Cytotechnologists/Trainees	\$50.00	\$100.00
Laboratory Assistants/Trainees	\$25.00	\$75.00
Phlebotomists	\$25.00	\$75.00

¹ Fees are not prorated (i.e. License received mid-year fee payable in full, next annual renewal payable in full)

It is unlawful to file false public records in any public office or with any public official. Refer to the application instructions when completing these forms. Carefully prepare responses. (Rev 090303)

8

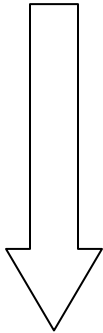
Insert Name: Same as 1a.	
2. Blank By Design	BLANK
3. Addresses Address <i>must</i> include physical address (i.e. street number, street name). If applicable, include apartment number with physical address. 3a. Mailing Address —This is the address to which correspondence will be forwarded by the LSBME. *This is the address that will appear in the <i>LSBME Official List</i> and will be provided to the public It is your responsibility to keep the LSBME apprised of all address changes. 3b. Permanent- Address -If same as mailing address, mark "X" here: <input type="checkbox"/> 3c. Business Address This is NOT the MAILING or PERMANENT addresses listed in items 3a and 3b.	3a. _____ Street Address Apt. # _____ Post Office Box (if applicable) _____ City Parish/County State Zip/Postal Code plus 4 _____ Country, if not U.S. 3b. _____ Street Address Apt. # _____ Post Office Box (if applicable) _____ City Parish/County State Zip/Postal Code plus 4 _____ Country, if not U.S. 3c. _____ Name of Business _____ Street Address P.O. Box (if applicable) _____ City Parish/County State Zip/Postal Code plus 4 _____ Country, if not U.S.
4. Telephone Numbers	_____ - _____ Ext. _____ Business Phone Home Phone _____ - _____ Business Fax Home Fax _____ - _____ Ext. _____ Cell Phone Pager
5. E-mail Address List primary and secondary e-mail addresses, if applicable.	_____ Primary E-mail Address _____ Secondary E-mail Address (if applicable)

Insert Name: Same as 1a.	
6. Date and Place of Birth Certified birth certificate or passport required. If passport submitted, explain why birth certificate is not available on separate 8 ½ "x 11" sheet of paper.	<div> <div> <div>_____</div> <div>Month</div> </div> <div> <div>_____</div> <div>Day</div> </div> <div> <div>_____</div> <div>Year</div> </div> </div> <div> <div>_____</div> <div>City</div> </div> <div> <div>_____</div> <div>Parish/County</div> </div> <div> <div>_____</div> <div>State (US only)</div> </div> <div> <div>_____</div> <div>Province/Territory</div> </div> <div> <div>_____</div> <div>Country</div> </div>
7. Nationality/ Citizenship If not native born U.S. citizen (born in U.S. or one of its territories), proof of U.S. citizenship or valid visa issued by U.S. Immigration and Naturalization required. Proof of U.S. citizenship can be documented by producing an <i>original</i> certificate of naturalization or certificate of birth to U.S. citizens traveling abroad. A valid visa is a visa issued by the Immigration and Naturalization Service authorizing a person to reside and work in the U.S. <i>No license or temporary permit for practice in Louisiana will be issued without production of above credentials.</i>	a. Are you an U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No b. If not native born citizen of the U.S., provide following: Type VISA: _____ If naturalized, provide certificate number: _____ INS number: _____ Petition number: _____ Date issued: _____ District Court through which issued: _____ Certificate of Citizenship certificate number: _____
8. Identification Numbers	<div> <div>_____ - _____ - _____</div> <div>U.S. Social Security Number</div> </div> <div> <div>_____</div> <div>Driver's License Number</div> </div> <div> <div>_____</div> <div>Issuing State</div> </div> <div> <div>_____</div> <div>National Identification Number</div> </div> <div> <div>_____</div> <div>Issuing Country</div> </div>
9. Gender	<div> <div>_____</div> <div>Male</div> </div> <div> <div>_____</div> <div>Female</div> </div>
10. Physical Description Use linear measure in feet and inches.	<div> <div> <div>Height _____</div> <div>Ft. In.</div> </div> <div> <div>Weight _____</div> <div>Lbs.</div> </div> <div> <div>Eyes _____</div> <div>Color</div> </div> <div> <div>Hair _____</div> <div>Color</div> </div> <div> <div>Race _____</div> <div>(Optional)</div> </div> </div> <div> <div>_____</div> <div>I have no physical mark(s).</div> </div> <div> <div>_____</div> <div>I have the following physical mark(s):</div> </div> <div> <div>_____</div> <div>Description of Mark</div> </div> <div> <div>_____</div> <div>Location</div> </div> <div> <div>_____</div> <div>Description of Mark</div> </div> <div> <div>_____</div> <div>Location</div> </div>
11. Military U.S. Active Duty	Have you ever served in the U.S. Military? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>If yes, Branch</i> _____ Dates served _____ Type Discharge _____

<p><i>Insert Name: Same as 1a.</i></p> <p>12. License/Permit History</p> <p>List States in which you obtained a License, Permit and/or Certification. Specify type, license number and date initially issued.</p> <p>Include <i>all</i> licenses, whether permanent or temporary.</p> <p>Does not apply, mark here <input type="checkbox"/></p>	<p>Louisiana _____ Date _____</p> <p>Other States: _____ Date _____</p> <p>_____ Date _____</p> <p>_____ Date _____</p> <p>_____ Date _____</p>
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To order criminal background materials, e-mail the LSBME at lsbmemat@lsbme.louisiana.gov . *Include the following information: Name, Mailing Address, & Phone Numbers.*

CONTINUE TO THE NEXT PAGE



Insert Name: Same as 1a.	
13. Third-Party Authorization	<div data-bbox="781 86 1175 117" data-label="Section-Header"> <p align="center">THIRD PARTY AUTHORIZATION</p> </div> <div data-bbox="418 123 1539 531" data-label="Text"> <p>I understand and acknowledge that the submission of an application to, as well as the acceptance or maintenance of, any license or permit (hereinafter referred to as a "license") issued by the Louisiana State Board of Medical Examiners (the "Board") shall constitute and operate as a perpetual authorization by me to each educational institution at which I have matriculated, each state or federal agency to which I have applied for any license, permit, certificate and/or registration, each person, firm, corporation, clinic, office or institution by whom or with whom I have been employed in the practice of medicine or as an allied health professional, each physician or other health care practitioner whom I have consulted or seen for diagnosis or treatment and each professional organization or specialty board to which I have applied for membership, to disclose and release to the Board any and all information and documentation concerning me which the Board may deem material to the consideration of my initial application and during such period as I may hold or maintain a license. With respect to any such information or documentation, the submission of an application to or the acceptance or maintenance of a license from the Board shall equally constitute and operate as a consent by me to the disclosure and release of such information and documentation and as a waiver by me of any privilege or right of confidentiality which I would otherwise possess with respect thereto.</p> </div> <div data-bbox="418 537 1539 690" data-label="Text"> <p>By submitting an application or accepting or maintaining a license issued by the Board, I shall be deemed to have given my consent to submit to physical or mental examinations if, when and in the manner so directed by the Board and to have waived all objections as to the admissibility or disclosure of findings, reports or recommendations pertaining thereto on the grounds of privileges provided by law. I acknowledge that the expense of any such examination shall be borne by me.</p> </div> <div data-bbox="418 697 1539 1104" data-label="Text"> <p>The submission of an application or the acceptance or maintenance of a license from the Board shall also constitute and operate as perpetual authorization and consent by me to the Board to disclose and release any information or documentation set forth in or submitted with my application, or which then or at any time thereafter may be obtained by the Board from other persons, firms, corporations, associations or governmental entities, to any person, firm, corporation, association or governmental entity having a lawful, legitimate and reasonable need therefor, including, without limitation, the medical and/or allied health professional licensing, permitting, certifying and/or registering authority of any state; the Federation of State Medical Boards of the United States; professional organizations, associations and societies; the American Medical Association and any component state, county or parish medical society, including but not limited to the Louisiana State Medical Society and component parish societies thereof; the American Osteopathic Association; the Louisiana Osteopathic Medical Association; the Federal Drug Enforcement Agency; the Louisiana Office of Narcotics and Dangerous Drugs, Office of Licensing and Registration, Department of Health and Hospitals; federal, state, county or parish and municipal health and law enforcement agencies and the Armed Services.</p> </div> <div data-bbox="418 1110 1539 1232" data-label="Text"> <p>I understand that this authorization and consent is valid commencing on the date herein below subscribed and that such will remain in force and effect until and unless I withdraw my application for, or no longer possess or maintain, a license issued by the Board. I also acknowledge that a duplicate of this document may serve as an original.</p> </div> <div data-bbox="902 1260 1539 1312" data-label="Text"> <p align="right">Signature: _____ Full Name</p> </div> <div data-bbox="914 1341 1503 1369" data-label="Section-Header"> <p align="center">**TO BE SIGNED IN THE PRESENCE OF A NOTARY</p> </div> <div data-bbox="418 1396 1034 1425" data-label="Text"> <p>Subscribed and sworn to before me this _____ day</p> </div> <div data-bbox="418 1478 1034 1507" data-label="Text"> <p>of _____, 20_____.</p> </div> <div data-bbox="418 1608 1034 1642" data-label="Text"> <p>_____ Notary Public</p> </div> <div data-bbox="1365 1614 1412 1642" data-label="Text"> <p align="right"><i>Seal</i></p> </div> <div data-bbox="418 1719 1034 1749" data-label="Text"> <p>MY COMMISSION EXPIRES: _____</p> </div>

<i>Insert Name: Same as 1a</i>			
14. Blank By Design	BLANK		
15. Examination History Provide the most recent examination date and total number of attempts for each examination you have taken for purposes of state medical licensure or permit.	<u><i>Clinical Laboratory Personnel</i></u>		
Complete all that apply	<u>Examination</u>	<u>Most Recent Attempt (Month/Year)</u>	<u>No. of Attempts</u>
Generalist	AMT	_____	_____
	ASCP	_____	_____
	AAB	_____	_____
	NCA	_____	_____
Specialist	AACC	_____	_____
	ABB	_____	_____
	ABFT	_____	_____
	ABHI	_____	_____
	ABI	_____	_____
	ASCP	_____	_____
	ASM	_____	_____
	NCA	_____	_____
Technician	AMT	_____	_____
	ASCP	_____	_____
	AAB	_____	_____
	NCA	_____	_____
Cytotechnologist	ASCP	_____	_____
	IAC	_____	_____
Laboratory Assistant	ISCLT(POLT)	_____	_____
	AMT(COLT)	_____	_____
	NHA	_____	_____
Phlebotomist	AABB	_____	_____
	AMT	_____	_____
	ASCP	_____	_____
	ASPT	_____	_____
	IAPS	_____	_____
	NAHTR	_____	_____
	NCA	_____	_____
	NHA	_____	_____
	NPA	_____	_____

Insert Name: Same as 1a.

16. Pre-Allied Health Education

List high school and all colleges and/or universities you attended **prior** to allied health program in chronological order, most recent listed first.

You may photocopy this page to report more than four (4) institutions, if necessary.

Account for **ALL** time since high school. If a break of six (6) months or more occurred during the attendance dates you provide, report the beginning and ending dates of this break on a separate 8 1/2" x 11" sheet of paper. It is not necessary to report breaks between institutions.

Name of Institution #1

Address

City

State

Country

Zip Code

Plus 4

From

Month

Year

To:

Month

Year

Degree: ☐ None

☐ **High School**

☐ B.A.

☐ B.S.

☐ M.A.

☐ M.S.

☐ Other: _____

Was any part of this education used as credit towards your allied health degree?

☐ Yes

☐ No

Name of Institution #2

Address

City

State

Country

Zip Code

Plus 4

From

Month

Year

To:

Month

Year

Degree: ☐ None

☐ B.A.

☐ B.S.

☐ M.A.

☐ M.S.

☐ Other: _____

Was any part of this education used as credit towards your allied health degree?

☐ Yes

☐ No

Name of Institution #3

Address

City

State

Country

Zip Code

Plus 4

From

Month

Year

To:

Month

Year

Degree: ☐ None

☐ B.A.

☐ B.S.

☐ M.A.

☐ M.S.

☐ Other: _____

Was any part of this education used as credit towards your allied health degree?

☐ Yes

☐ No

Name of Institution #4

Address

City

State

Country

Zip Code

Plus 4

From

Month

Year

To:

Month

Year

Degree: ☐ None

☐ B.A.

☐ B.S.

☐ M.A.

☐ M.S.

☐ Other: _____

Was any part of this education used as credit towards your allied health degree?

☐ Yes

☐ No

<p>Insert Name: Same as 1a</p> <p>17A. Allied Health Education</p> <p>If does not apply, mark "X" here: <input type="checkbox"/></p> <p>List all of the allied health programs attended in chronological order, beginning with most recent school attended.</p> <p>Photocopy this page to report more than two (2) institutions, if necessary.</p> <p>If necessary, you may continue your explanation of Unusual Circumstances on a separate 8 1/2"x 11" sheet of paper. Your response may not exceed 100 words per question.</p> <p><u>DOCUMENTATION:</u> Include an official transcript from your college or university. If currently a student in an accredited program, send transcript after degree has been awarded.</p>	<div style="border-bottom: 1px solid black; margin-bottom: 10px;"> <p>Complete Name of Institution # 1 (Do Not abbreviate)</p> <p>Street Address, City, State, Country (if not U.S.), Zip Code</p> <p>Month / Date / Year Commenced _____ Month / Date / Year Graduated _____</p> <p>_____ Degree _____ Did Not Graduate</p> <p>Unusual Circumstances (check Yes or No)</p> <p>Did you take a leave(s) of absence or break(s) from your allied health education? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Were you ever placed on probation?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Were you ever disciplined or placed under investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Were any negative reports ever filed against you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Were any limitations or special requirements imposed on you because of academic incompetence, disciplinary problems or for any other reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please explain each "Yes" response from above:</p> <p>_____</p> <p>_____</p> </div> <hr/> <div style="border-bottom: 1px solid black; margin-bottom: 10px;"> <p>Complete Name of Institution # 2 (Do Not Abbreviate)</p> <p>Street Address, City, State, Country (if not U.S.), Zip Code</p> <p>Month / Date / Year Commenced _____ Month / Date / Year Graduated _____</p> <p>_____ Degree _____ Did Not Graduate</p> <p>Unusual Circumstances (check Yes or No):</p> <p>Did you take a leave(s) of absence or break(s) from your allied health education? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Were you ever placed on probation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Were you ever disciplined or placed under investigation? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Were any negative reports ever filed against you? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Were any limitations or special requirements imposed on you because of Academic incompetence, disciplinary problems or for any other reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please explain each "Yes" response from above:</p> <p>_____</p> <p>_____</p> </div>				
<p>17B. Practice History and Non-Professional Activity</p> <p>(Do NOT include Training) Account for ALL time, in chronological order, from High School to the present.</p>	From Month/Year	To Month Year	Location City/State	Employer/Practice	Specialty/Activity



Louisiana State Board of Medical Examiners

P. O. Box 30250, New Orleans, LA 70190-0250
Telephone: (504) 568-6820

OATH OR AFFIRMATION

Answer the following questions

(Yes answers must be explained in sworn affidavit ***-AFFIDAVIT MUST BE TYPED!***)

	YES	NO
1. In the five years prior to this application, have you had any physical injury or disease or mental illness or impairment, which could reasonably be expected to affect your ability to practice medicine or other health profession?		
2. In the five years prior to this application, have you been addicted to or used in excess any drug or chemical substance including alcohol or treated through a drug or alcohol rehabilitation program?		
3. Have you ever, either as an adult or juvenile, been cited, arrested, charged, convicted or pled nolo contendere to, violation of any: a) State statute? b) Federal statute?		
4. Has your application for examination or license ever been rejected or denied?		
5. Have you ever failed a licensure/certification examination? If yes, how many times? _____		
6. Have you ever been denied membership in a state, county, or local professional society?		
7. Has your membership in a state, county, or local professional society ever been revoked, suspended, placed on probation, or restricted in any manner?		
8. Have you ever been denied, had suspended, revoked or restricted, or voluntarily relinquished, staff or clinical privileges in any hospital or other health care institution or organization?		
9. Have you had any malpractice claims filed, settled or adjudicated against you within the last five (5) years?		
10. Have you ever voluntarily surrendered, or did you have suspended, revoked or restricted, your narcotics controlled substances license or registration (state or federal)?		
11. Have you ever voluntarily surrendered, or did you have suspended, revoked, placed on probation, or restricted in any manner, any professional license issued by any licensing authority?		
12. Have you ever been the subject of any type of disciplinary action or inquiry by any licensing agency, hospital, institution, society, etc.?		
13. Have you ever agreed not to seek re-licensure in any licensing jurisdiction?		
14. Have you ever been, or are you currently in the process of being denied, terminated, suspended, refused, limited, placed on probation or placed under other disciplinary action with respect to your participation in any private, state, or federal health insurance program (e.g., Medicare, Medicaid)?		
15. Has any court determined you are currently in violation of a court's judgment or order for the support of dependent children?		

OATH OR AFFIRMATION OF APPLICANT

I HEREBY swear or affirm that all statements made and information provided in or with this application are true, correct and complete; that I am the person named in the credentials herewith presented and that I am the original and lawful possessor of such documents; that the photograph submitted to LSBME is a true likeness of me and that it was taken within the last 60 days; that in consideration of the issuance to me of a license/certificate to practice in Louisiana, I swear that I shall observe, abide by and uphold the laws of the State of Louisiana governing my practice and that I shall abstain from unethical, deceptive and fraudulent methods of practice and from immoral, unprofessional and unethical conduct, and that I shall not associate professionally with nor become a partner or employee of any person who resorts to such practices. I hereby agree that the violation of this oath shall constitute cause sufficient for the revocation of said license/certificate and surrender of the rights and privileges accorded me thereunder.

Signed _____ Full Name

Subscribed and sworn to before me this _____ day

of _____ YEAR _____

NOTARY PUBLIC

My commission expires _____

Louisiana State Board of Medical Examiners

P. O. Box 30250, New Orleans, LA 70190-0250

Telephone: (504) 568-6820

CERTIFICATE OF PROGRAM CHAIRMAN/HEAD

APPLICANT'S NAME

SOCIAL SECURITY NUMBER

Section 1: To Applicant— Complete Section 1 before a Notary. Forward this form to your Program Chairman/Head of Allied Health School for completion.

Recent photograph

Passport quality photograph of applicant securely affixed. 2" x 2" clear, front view, full face without hat or dark glasses. Full-length photograph, black and white or computer-generated will not be accepted. Applicant is to sign name across bottom of photograph, partly on photograph and partly upon the page.

***Affix Photograph
Here***

(Follow directions carefully.)

***Notary is to affix seal
directly on photograph.***

I certify that the photograph is a true likeness of _____ (Applicant).

On this the _____ Day of _____, 200_____

Notary Public

My commission expires _____

Section 2: To Program Director of Accredited Program--After completion of this form, return to Office of Licensure, Louisiana State Board of Medical Examiners, P. O. Box 30250, New Orleans, LA 70190-0250. DO NOT RETURN TO APPLICANT.

I hereby certify that _____

Whose photograph appears above, was awarded the degree or is scheduled to be awarded a degree of, or certificate in, _____

Dated _____ from this school.

Name of school/program

Signature of Registrar or Program Director

Address

Title

Date

Affix School Seal Here

Louisiana State Board of Medical Examiners

P. O. Box 30250, New Orleans, LA 70190-0250

Telephone: (504) 568-6820

****To be completed if applicant has ever been licensed in another state****

VERIFICATION / ENDORSEMENT

Section 1: To Applicant— Complete Section 1 of this form and forward it to the licensing agency of each state in which you have ever obtained licensure/certification, whether permanent or temporary. If necessary, this form may be duplicated.

I hereby authorize the licensing agency of the State of _____ to release all information on file concerning me, favorable or otherwise, to the Louisiana State Board of Medical Examiners.

TYPE OR PRINT YOUR FULL NAME

SIGNATURE

LICENSE NUMBER AND DATE ISSUED

ADDRESS

SOCIAL SECURITY NUMBER

CITY, STATE, ZIP CODE

Section 2: THE SECTION BELOW IS TO BE COMPLETED BY THE VERIFYING/ENDORING STATE and returned to the Louisiana State Board of Medical Examiners, P.O. Box 30250, New Orleans, LA 70190-0250. This form is NOT to be returned to the Applicant.

A. This is to certify that the records of the licensing Board of the State of _____ indicate that the above-named individual was issued license/certificate No. _____ dated _____ on the basis of written examination (state name of examination) _____; reciprocity with the state of _____; other basis (please name) _____.

B. If State Board Examination, provide statement of grades or attach hereto.

C. Provide the following:

1. Is this license/certificate current? ☐ Yes ☐ No ☐ Cannot Divulge
2. Is this license/certificate in good standing? ☐ Yes ☐ No ☐ Cannot Divulge
3. Has this individual ever been warned or reprimanded? ☐ Yes ☐ No ☐ Cannot Divulge
4. Has this individual license/certificate ever been revoked? ☐ Yes ☐ No ☐ Cannot Divulge
5. Has this individual license/certificate ever been suspended? ☐ Yes ☐ No ☐ Cannot Divulge
6. Has this individual license/certificate ever been placed on probation? ☐ Yes ☐ No ☐ Cannot Divulge
7. Has this individual license/certificate ever been restricted in any manner? ☐ Yes ☐ No ☐ Cannot Divulge
8. Has this individual ever had any charges filed against him/her? ☐ Yes ☐ No ☐ Cannot Divulge
9. Do you know of any information that may be a discredit to this person? ☐ Yes ☐ No ☐ Cannot Divulge
10. Do your files indicate any derogatory information whatsoever? ☐ Yes ☐ No ☐ Cannot Divulge

REMARKS _____

Date

Signature

Title

BOARD SEAL

Name and address of licensing agency

NOTE TO BOARD COMPLETING THIS FORM: If answer to 1 or 2 is "No", or 3 through 10 is "Yes", explain and attach certified copies of pertinent material (i.e., Notice of Hearing, Final Decision, Consent Order/Agreement, etc.).

Louisiana State Board of Medical Examiners

P. O. Box 30250, New Orleans, LA 70190-0250

(504) 568-6820

REQUEST FOR EXAMINATION RESULTS

Applicant: Contact examination agency to determine monies necessary to request scores. See “Examination Contacts” in the LSBME application instructions. Complete Sections 1 and 2 and send this page to the examining agency after examination has been completed. Examining agency will send results to the Louisiana State Board of Medical Examiners.

Section 1: To Applicant: Print you name and address *as it appears on your examination application form*.

Name: _____
(Last) (First) (Middle)

Address: _____
(Number & Street) (Apartment Number)

(City) (State) (Zip Code + 4)

Social Security Number: _____ - _____ - _____

Section 2: To the Examination Agency from Applicant:

Gentlemen:

I am applying for licensure/reinstatement/re-licensure to practice in Louisiana. This is your authorization to release my examination results (on file and future examination results), favorable or otherwise, and mail them to the Louisiana State Board of Medical Examiners. **See Section 3 below.**

(Signature)

(Date)

Section 3: To Examination Agency:

Mail examination results to: **Louisiana State Board of Medical Examiners, Licensure Division, P. O. Box 30250, New Orleans, LA 70190-0250. DO NOT mail to Applicant.** The LSBME will NOT accept this information from any source other than the examination entity.

Clinical Laboratory Personnel
P. O. Box 2270
New Orleans, LA 70176-2270

VERIFICATION OF EXPERIENCE, COMPETENCY AND PROFICIENCY

INSTRUCTIONS: Please have your Laboratory Supervisor/Medical Director and Personnel Director verify your experience on this form if experience is to be used as part of the criteria to qualify for licensure. **If you hold a current national certification in the license category you are applying for, you do not need to complete this form.**

_____ is/was employed in the laboratory at

_____ from _____ to _____.

His/Her duties were at the level of:

_____ CLS-G	_____ Cytotechnologist
_____ CLS-S	_____ Laboratory Assistant
_____ CLS-T	_____ Phlebotomy

This laboratorian either supervised or performed in the following sub-specialty areas and was found to be competent and proficient:

<input type="checkbox"/> Mycology/TB	<input type="checkbox"/> Serology/Immunology	<input type="checkbox"/> Histology
<input type="checkbox"/> Parasitology	<input type="checkbox"/> Clinical Chemistry	<input type="checkbox"/> Cytology
<input type="checkbox"/> Virology	<input type="checkbox"/> Hematology	<input type="checkbox"/> Radioassay
<input type="checkbox"/> Bacteriology	<input type="checkbox"/> Immunohematology	<input type="checkbox"/> Cytogenetics
<input type="checkbox"/> Phlebotomy	(Blood Banking)	<input type="checkbox"/> Flow
<input type="checkbox"/> ABO and/or Rh		<input type="checkbox"/> _____ % of time

How was competency/proficiency determined? _____

Date Form Completed

Laboratory Director/Medical Director

Date Form Completed

Personnel Director

Copies of this form may be made for additional employment verification.

[Revised 08/25/2004]

CLINICAL LABORATORY PERSONNEL COMMITTEE

**Louisiana State Board of Medical Examiners
Clinical Laboratory Personnel
P.O. Box 2270
New Orleans, LA 70176-2270
Telephone: 504-568-6820
Fax: 504-599-0503**

LABORATORY ASSISTANT CHECKLIST INSTRUCTIONS (Rev. 080305)

To verify that each laboratory assistant-trainee has completed in-house training, is proficient and competent to perform clinical procedures, and should be upgraded to Laboratory Assistant, please complete the following checklist.

1. Insert employee's name at top of each page.
2. Date and document on each date that a specific procedure is checked off.
3. The person evaluating each procedure should initial the appropriate blank.
4. Place a check mark to indicate competence for each procedure performed.
5. If your laboratory assistant does not perform any of the listed procedures, mark with the letter X
6. Page eight must be signed by the employee and the Laboratory/Medical Director and dated.
7. Each page must be signed at the bottom by the lab director.
8. The last page must include printed name, signature and contact information of the lab director.

This completed form is to be returned with your renewal form.

If you have questions, please call:

Roxanne Stears
(337) 826-5187

CLINICAL LABORATORY PERSONNEL COMMITTEE COMPETENCY ASSESSMENT CHECKLIST

Page 1
(Rev. 040303)

NAME: _____ JOB TITLE: LABORATORY ASSISTANT

NOTE: This is a representative sample of the technical competences necessary for safe clinical practice.

DEMONSTRATES PROFICIENCY IN PERFORMING TECHNICAL PROCEDURES SAFELY IN ACCORDANCE WITH DIVISION STANDARDS AS EVIDENCE BY UNIT-SPECIFIED CRITERIA.	COMPETENCY		Date	Initials
	Not Competent	Competent		
A. Hematology Specific:				
1. Instrument: _____				
a. Review Policy/Procedure Manual				
b. Daily startup procedure				
c. Run and review QC				
d. Perform corrective action if QC exceeds limits				
e. Analyze patient samples and review results				
f. Correction of lipemia, high WBC's/platelets, cold agglutinins				
g. Report and file results				
h. Correlate patient results with peripheral smear				
i. Perform manual differentials				
j. Correction for nucleated RBC's				
k. Perform preventative maintenance				
l. Trouble shooting				
2. Coagulation Instrument: _____				
a. Review Policy/Procedure Manual				
b. Daily startup procedure				
c. Run and review QC				
d. Perform corrective action if QC exceeds limits				
e. Analyze patient samples and review results-PT and APTT				
f. Report and file results				
g. Trouble shooting				
3. Urinalysis instrument: _____				
a. Review Policy/Procedure Manual				
b. Daily startup procedure				
c. Run and review QC				
d. Perform corrective action if QC exceeds limits				
e. Analyze patient samples and review results				
f. Review results				
g. Perform urine microscopic				
h. Report and file results				
i. Correlate microscopic with urine chemistries				

Laboratory Director's Signature: _____

CLINICAL LABORATORY PERSONNEL COMMITTEE COMPETENCY ASSESSMENT CHECKLIST

Page 2
(Rev. 040303)

NAME: _____ JOB TITLE: LABORATORY ASSISTANT

DEMONSTRATES PROFICIENCY IN PERFORMING TECHNICAL PROCEDURES SAFELY IN ACCORDANCE WITH DIVISION STANDARDS AS EVIDENCE BY UNIT-SPECIFIED CRITERIA.	COMPETENCY		Date	Initials
	Not Competent	Competent		
4. Miscellaneous Tests: Perform the following tests:				
a. Sed Rates				
b. Reticulocyte Count				
c. Platelet Count				
d. FDP				
e. XDP				
f. Thrombin Time				
g. Protamine Sulfate				
h. APTT				
i. Prothrombin Time				
j. Simplate Bleeding Time				
k. Eosinophil Count				
l. Red Cell Fragility				
m. Sperm Count				
n. Sucrose Hemolysis Test				
o. Viscosity				
p. Body Fluids-spinal, synovial, pleural, peritoneal				
q. Preparation of reagents				
r. Absolute Granulocyte Count				
s. Sickle Cell Testing				
t. Circulating Anticoagulant Screen				
u. Addis Count				
v. Clinitest				
w. Ictotest				
x. Cystine Determination-urine				
y. Urine Hemosiderin				
z. Specific Gravity				
aa. Joint Fluid Crystal Examination				
bb. Assist with Bone Marrows				
B. Chemistry Specific				
1. Instrument: _____				
a. Review Policy/Procedure Manual				
b. Daily startup procedure				
c. Run and review QC				
d. Perform and document corrective action if QC exceeds limits				
e. Analyze patient samples and review results				
f. Analyze and calculate timed urine chemistries				
g. Correlate patient results with previous results				
h. Perform preventive maintenance				

Laboratory Director's Signature: _____

CLINICAL LABORATORY PERSONNEL COMMITTEE COMPETENCY ASSESSMENT CHECKLIST

Page 3
(Rev. 040303)

NAME: _____ JOB TITLE: LABORATORY ASSISTANT

DEMONSTRATES PROFICIENCY IN PERFORMING TECHNICAL PROCEDURES SAFELY IN ACCORDANCE WITH DIVISION STANDARDS AS EVIDENCE BY UNIT-SPECIFIED CRITERIA.	COMPETENCY		Date	Initials
	Not Competent	Competent		
i. Perform calibration of instrument				
j. Perform body fluid analysis				
k. Report and file results				
l. Troubleshooting				
D. Immunology, Parasitology Specific:				
1. Performance of the following manual tests:				
a. Amniostat test for Phosphatidyl Glycerol				
b. APT Test				
c. Bactigen Panel on serum, CSF, or Urine				
d. Gastric Occult Blood				
e. Hemophilus influenzae on serum, CSF, or Urine				
f. Mono Test				
g. N. meningitidis on serum, CSF, or Urine				
h. Urine Pregnancy Test				
i. Respiratory Syncytial Virus				
j. Strep A Screen				
k. Strep B Agglutination on serum, CSF, or Urine				
l. Strep B Agglutination—Vaginal				
m. Strep pneumonia on Serum, CSF or Urine				
n. Stool examination for occult blood (guaiaac)				
o. Rotavirus				
p. Total IgE and Specific IgE antibodies				
E. Blood Bank Specific -Perform following procedures				
1. ABO Forward Grouping				
2. ABO Reverse Grouping				
3. Rh typing including Du				
4. Antibody Detection				
5. Antibody Identification				
6. Antibody Titration				
7. Antibody Elution				
8. Antigen Typing				
9. Prewarming Warning				
10. Collection of Therapeutic Phlebotomy				
F. Microbiology Specific				
1. Miscellaneous Equipment				
a. Microscopes-operation and maintenance				
b. Electric incinerators- operation and maintenance				

Laboratory Director's Signature: _____

CLINICAL LABORATORY PERSONNEL COMMITTEE COMPETENCY ASSESSMENT CHECKLIST

Page 4
(Rev. 040303)

NAME: _____ JOB TITLE: LABORATORY ASSISTANT

DEMONSTRATES PROFICIENCY IN PERFORMING TECHNICAL PROCEDURES SAFELY IN ACCORDANCE WITH DIVISION STANDARDS AS EVIDENCE BY UNIT-SPECIFIED CRITERIA.	COMPETENCY		Date	Initials
	Not Competent	Competent		
c. Anaerobic Gaspak Jars- operation and maintenance				
2. Culture Routine – Respiratory				
a. Review Policy/Procedure Manual				
b. Procure specimen				
c. Plant specimen				
3. Culture Routine – Blood				
a. Review Policy/Procedure Manual				
b. Procure specimen				
c. Plant specimen				
4. Culture Routine – Urine				
a. Review Policy/Procedure Manual				
b. Procure specimen				
c. Plant specimen				
5. Culture Routine – Stool				
a. Review Policy/Procedure Manual				
b. Procure specimen				
c. Plant specimen				
6. Culture Routine – Miscellaneous				
a. Review Policy/Procedure Manual				
b. Procure specimen				
c. Plant specimen				
7. Culture AFB				
a. Review Policy/Procedure Manual				
b. Procure specimen				
c. Plant specimen				
8. Culture Fungus				
a. Review Policy/Procedure Manual				
b. Procure specimen				
c. Plant specimen				
9. Direct Exam Procedures				
a. Review Policy/Procedure Manual				
b. Gram Stain- QC, performance, reading, reporting				
c. India Ink- Performance, reading, reporting				
d. Wet Prep- Performance, reading, reporting				
e. KOH Prep- Performance, reading, reporting				
f. Direct Acid Fast Stain- Performance, reading, reporting				
10. Skin Tests				
a. Review Policy/Procedure Manual				
b. Preparation				
c. Administration				
d. Reading and reporting				
G. Histology Specific				
1. Departmental Specific Duties				
a. Proper fixation of tissue				

Laboratory Director's Signature: _____

CLINICAL LABORATORY PERSONNEL COMMITTEE COMPETENCY ASSESSMENT CHECKLIST

Page 5
(Rev. 040303)

NAME: _____ JOB TITLE: LABORATORY ASSISTANT

DEMONSTRATES PROFICIENCY IN PERFORMING TECHNICAL PROCEDURES SAFELY IN ACCORDANCE WITH DIVISION STANDARDS AS EVIDENCE BY UNIT-SPECIFIED CRITERIA	COMPETENCY		Date	Initials
	Not Competent	Competent		
b. Receiving and preparing specimens for grossing				
c. Processing of tissue specimens				
d. Embedding of tissue specimens				
e. Cutting tissue specimens				
f. Staining and coverslipping specimens				
g. Preparation of frozen specimens				
h. Decalcification of routine bones				
i. Retention of blocks and slides				
j. Disposal of tissue				
k. Processing of bone marrow				
l. Staining of bone marrow				
m. Proper cleanup of grossing area				
n. Proper usage and changing of solutions on tissue processor				
o. Sharpening of knives				
p. Preparation and use of the following special stains				
1) Masson's Trichrome				
2) Verhoeff's Elastic				
3) Hematoxylin Stain				
4) Gomori's Reticulum				
5) May-Grunwald Giemsa				
6) Oil Red O				
7) Periodic – Acid – Schiff				
8) Mucicarmine				
9) Bennhold's Congo Red Amyloid				
10) Acid Fast Bacteria				
11) Methenamine-Silver Nitrate				
12) Van Fieson's Collagen				
13) Iron Hematoxylin				
14) Brown & Hopps Gram				
15) Gomori's Iron Reaction				
16) Sudan IV Fat				
17) Fontana Masson for Argentaffin				
18) Pascual's for Argentaffin				
19) Other Stains				
q. Preparation and use of Immunoperoxidase Stains				

Laboratory Director's Signature: _____

CLINICAL LABORATORY PERSONNEL COMMITTEE COMPETENCY ASSESSMENT CHECKLIST

Page 6
(Rev. 040303)

NAME: _____ JOB TITLE: LABORATORY ASSISTANT

DEMONSTRATES PROFICIENCY IN PERFORMING TECHNICAL PROCEDURES SAFELY IN ACCORDANCE WITH DIVISION STANDARDS AS EVIDENCE BY UNIT-SPECIFIED CRITERIA	COMPETENCY		Date	Initials
	Not Competent	Competent		
1) Anaplastic Tumor Identification				
2) Carcinoembryonic Antigen				
3) Keratin				
4) Prostatic Specific Antigen				
5) S-100				
6) Melanoma (HMB-45)				
7) Glial Fibrillary Acidic Protein				
8) Other Stains				
r. Miscellaneous Procedures				
1) Microtome operation and maintenance				
2) Cryostat operation and maintenance				
3) Tissue processor operation and maintenance				
4) Embedding center operation and maintenance				
5) Microwave operation and maintenance				
6) Knife sharpener operation and maintenance				
7) Oven and hot plate operation and maintenance				
8) Refrigerator operation and maintenance				
9) Orientation to Chemical Hygiene Plan				
I. Cytology Specific				
1. Departmental Specific Duties				
a. Specimen Processing				
1) Assist with collection of the following specimens				
a) Bronchoscopy				
b) Fine needle aspirations				
c) Cyst aspirates				
d) Buccal smears				
e) Renal biopsies				
f) Effusions				
g) Pleural biopsy				
2) Logging and accessioning of specimens				
3) Fixation of specimens				
4) Staining and coverslipping				
5) Processing of specimens by centrifuge method				
6) Processing by cytocentrifuge method				
7) Preparation of slides for Gram stain and AFB				
8) Filing slides, requisitions, and reports				

Laboratory Director's Signature: _____

CLINICAL LABORATORY PERSONNEL COMMITTEE COMPETENCY ASSESSMENT CHECKLIST

Page 7
(Rev. 040303)

NAME: _____ JOB TITLE: LABORATORY ASSISTANT

DEMONSTRATES PROFICIENCY IN PERFORMING TECHNICAL PROCEDURES SAFELY IN ACCORDANCE WITH DIVISION STANDARDS AS EVIDENCE BY UNIT-SPECIFIED CRITERIA	COMPETENCY		Date	Initials
	Not Competent	Competent		
9) Miscellaneous procedures				
a) Preparation of solutions				
1) Carbowax				
2) Cresyl violet				
3) 3% Amphyl				
4) 10% Clorox				
5) Scott's Tap Water				
6) Saponin				
b) Centrifuge operation and maintenance				
c) Fume/biological hood operation and maintenance				
d) Microscope operation and maintenance				
J. General Laboratory				
1. Miscellaneous Duties				
a. Microscope operation and maintenance				
b. Centrifuge operation and maintenance				
c. Refractometer operation and maintenance				
d. Cytospin operation and maintenance				
e. Hood operation and maintenance				
f. Reporting and recording of panic values				
g. Proper storage of specimens for later testing				
h. Departmental record completion				
i. Departmental sample preparation				
j. Referral testing – sample requirements, packaging, reporting				
2. Specimen procurement				
a. Patient and sample identification				
b. Collection of samples				
c. Specimen labeling				
d. General venipuncture				
e. Heelstick				
f. Fingerstick				
g. Whole blood beside glucose testing				
h. Whole blood beside testing- other				
3. Preparation of peripheral blood smears				
4. Collection of specimens for microbiology				
5. Emergency identification procedures				

Laboratory Director's Signature: _____

CLINICAL LABORATORY PERSONNEL COMMITTEE COMPETENCY ASSESSMENT CHECKLIST

Page 8
(Rev. 040303)

NAME: _____ JOB TITLE: LABORATORY ASSISTANT

DEMONSTRATES PROFICIENCY IN PERFORMING TECHNICAL PROCEDURES SAFELY IN ACCORDANCE WITH DIVISION STANDARDS AS EVIDENCE BY UNIT-SPECIFIED CRITERIA	COMPETENCY		Date	Initials
	Not Competent	Competent		
6. Specimen collection for drug testing				
7. Handling of biohazardous materials/waste				
8. Guidelines for specimen rejection/acceptance				
9. Participation in proficiency testing program				

Employee: Signature: _____ Date: _____

Lab Director: Print Name/Position: _____ Date: _____

☐ Hospital ☐ Laboratory ☐ Clinic ☐ Business

Institution: _____

Address: _____

Telephone #: _____

Signature: _____

Laboratory Director's Signature: _____